IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
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CERTIFIED MAIL: 7005 1160 0000 1506 9223

December 8, 2008

Brian V. Sawyer, Administrator
Aspen Park Healthcare
420 Rowe Street
Moscow, ID 83843

Provider #: 135093

Dear Mr. Sawyer:

On **November 21, 2008**, a Recertification and State Licensure survey was conducted at Aspen Park Healthcare by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567, listing Medicare/Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567 and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 22, 2008**. Failure to submit an acceptable PoC by **December 22, 2008**, may result in the imposition of civil monetary

penalties by **January 12, 2009**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **December 26, 2008 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **December 26, 2008**. A change in the seriousness of the deficiencies on **December 26, 2008**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 26, 2008** includes the following:

Denial of payment for new admissions effective **February 21, 2009**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 21, 2009**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **November 21, 2008** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach2.pdf

This request must be received by **December 22, 2008**. If your request for informal dispute resolution is received after **December 22, 2008**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Loretta Todd

LORETTA TODD, R.N.
Supervisor
Long Term Care

LT/dmj

Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135093	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 11/21/2008
NAME OF PROVIDER OR SUPPLIER **ASPEN PARK HEALTHCARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **420 ROWE STREET MOSCOW, ID**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	483.20(g) - (j) RESIDENT ASSESSMENT

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, it was determined the facility had failed to ensure that the information documented on the MDS was accurate and reflected the status of the resident. This was true for 2 of 13 (#s 2 & 5) sampled residents. Findings include:

1. Resident #2 was admitted to the facility 9/08/08 with diagnoses of traumatic hip fracture, impaired renal function, diabetes mellitus type two, and chronic obstructive pulmonary disease.

The most recent initial assessment, dated 10/10/08, documented in Section AB. Demographic Information, under #10 Conditions Related to MR/DD Status, that the resident had MR/DD with no organic condition.

The nurse that completed the assessment was interviewed on 11/20/08 at 3:10 p.m. about the coding for this area, and the supporting documentation to show the resident had a mental retardation diagnosis was requested. The nurse provided a cardiac consultation from 03/07/03 that made a statement that the resident had "developmental delay." The residents physician, who had followed the resident for many years, was consulted and provided documentation that the resident "does not have a diagnosis of mental retardation or developmental delay."

2. Resident #5 was admitted to the facility 1/29/04, with diagnoses of Alzheimers, depressive disorder, and malignant neoplasm in the cecum.

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	Continued From Page 1 The Resident's Annual MDS assessment, dated 9/11/08, documented the resident was totally dependent on 1 - 2 staff for locomotion, dressing, toilet use, and personal hygiene. This need for total assistance indicated an increased need for help with ADLs when compared to the resident's Quarterly MDS assessment, dated 6/22/08. The 6/22/08 MDS, documented the resident only required extensive assistance. Resident #5's nursing records and ADL Flow Sheets for June 2008 - November 2008, were reviewed for increased need for assistance with ADLs over the past quarter. These records did not show a decline in the resident's ability to perform ADLs. The resident was consistently documented as requiring total assistance with all ADLs except eating. The records documented the resident required set up assistance and cuing with eating. Resident #5 was observed throughout the survey on 11/17/08, 11/18/08 and 11/19/08. During all observations of care and dining, the resident required total assistance with all ADLs except eating. During an interview, on 11/20/08 at 1:30 p.m., a CNA stated she had worked with Resident #5 for more than a year. The CNA reported that the resident's ability to perform ADLs had not noticably changed over the past several months. During an interview, on 11/21/08 at 11:35 a.m., the MDS nurse and Utilization Coordinator (URC) stated the 6/22/08 MDS was coded incorrectly and did not reflect the resident's functional ADL status on that date. The MDS nurse provided ADL Flow Sheets for June through September 2008, that demonstrated the resident consistently required total assistance with all ADLs except eating. The ADL Flow Sheets demonstrated the residents ability to perform ADLs and the amount of staff assistance required had not changed for at least 6 months. The URC stated the facility had recently terminated the prior MDS nurse after identifying that the MDSs were not completed correctly. The URC stated that current MDS nurse was in the process of correcting several identified MDS issues including coding errors.
F 286	483.20(d) RESIDENT ASSESSMENT - USE A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility had failed to keep 15 months of assessments in the residents active file. This was true for 2 of 13 (#s 2 & 4) sampled residents. Findings include: 1. Resident #4 was admitted to the facility 8/15/08 with diagnoses of diabetes mellitus type two, amputation of legs bilateral, hypertension, and peripheral vascular disorder.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135093	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 11/21/2008
NAME OF PROVIDER OR SUPPLIER **ASPEN PARK HEALTHCARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **420 ROWE STREET MOSCOW, ID**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 286	Continued From Page 2 The most recent significant change MDS, dated 8/22/08, was the only assessment in the medical record. The medical records supervisor was interviewed on 11/19/08 at 11:22 a.m. and stated that the resident had been at the facility for several years. The resident had just returned from the hospital after a significant illness. The medical records supervisor had been off work and said the person filling in for her had failed to bring the previous assessments forward from the previous medical record. 2. Resident #2 was admitted to the facility 9/08/08 with diagnoses of traumatic hip fracture, impaired renal function, diabetes mellitus type two, and chronic obstructive pulmonary disease. The most recent initial assessment, dated 10/10/08, was the only assessment in the medical record. The medical records supervisor was interviewed on 11/19/08 at 11:22 a.m. and stated that the resident had been at the facility for several years. The resident was discharged to the hospital with "return anticipated." The medical records supervisor had been off work and said the person filling in for her had failed to bring the previous assessments forward from the previous medical record.

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	135093	A. BUILDING _____ B. WING _____	11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN PARK HEALTHCARE	420 ROWE STREET MOSCOW, ID 83843

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey of your facility. The surveyors conducting the survey were: Mark Sawmiller, RN, Team Coordinator Arnold Rosling, RN, QMRP Lorraine Hutton, RN Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record FSM = Food Service Manager	F 000	**This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Aspen Park Healthcare does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.** RECEIVED DEC 22 2008 FACILITY STANDARDS	
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge	F 157	F 157 **Resident Specific** **Resident # 7's physician was notified regarding changes in respiratory status. The plan of care and orders were updated as indicated.** **Other Residents** **Interdisciplinary Team (IDT) reviewed other residents for physician notification of changes. No other concerns were identified.** **Facility Systems** **Licensed nursing (LN) staff are educated to notify the resident physician with change of condition to include but not limited to, change in oxygen needs. LN re-education**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Susan V Sam — Executive Director — 12/18/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to notify a resident's physician of the increased need for PRN (as needed) oxygen at night. This was true for 1 of 4 (#7) sampled residents reviewed for oxygen use. The Findings include: Resident #7 was admitted to the facility on 7/3/08, with diagnoses of dementia, chronic obstructive pulmonary disease, hypertension, and type 2 insulin dependent diabetes. Resident #7s Physician's Recapitulation (Recap) Orders for November 2008, documented, "O2 PRN to keep sats > 90% [Oxygen as needed to keep SpO2 greater than 90%]." Resident #7's Treatment Records, Nurse Progress Notes, and Vital Sign Flow Sheets, dated 9/1/08 through 11/18/08, were reviewed for	F 157	**was provided for physician notification system and parameters.** **Monitor** **The Director of Nursing Services (DNS) and/or designee will review residents for change in condition and timely physician notification. Any concerns will be addressed immediately and discussed with the Performance Improvement (PI) committee as indicated. The PI committee may adjust frequency of the monitoring, as it deems appropriate.** **Date of Compliance** **December 26, 2008**	

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F 157	Continued From page 2 SpO2 monitoring and prn oxygen use: September 2008 - October 2008 The Treatment Records and/or Vital Sign Flow Sheets documented the resident's SpO2 was monitored at least one time per day. The SpO2 ranged from 90% to 99%. No oxygen use was recorded for the months of September thru October. November 2008 The Treatment Records and/or Vital Sign Flow Sheets for 11/08 documented the resident's SpO2 was monitored at least one time per day between 11/1/08 and 11/18/08. Starting 11/5/08 the Treatment sheet documented the resident's SpO2 was also taken at least once per night. The SpO2 ranged from 87% to 99%. The Treatment Record also documented that Resident #7 was placed on 1 L to 3 L of O2 every night between 11/5/08 and 11/18/08. The treatment records did not document a rationale for initiating and maintaining the 02 therapy every night. The Nurse Progress Notes, dated 11/1/08 thru 11/18/08, did not address the increased use of oxygen at night nor did they document that the resident's physician was notified of the increased use of oxygen. On 11/18/08 at 7:05 a.m., Resident #7 was observed sleeping in bed. An oxygen concentrator at her bedside was running. A nasal cannula was connected to the concentrator but rested at the resident's side rather than in her nose. At 7:30 a.m., on 11/18/08, Resident #7 continued to sleep with the Oxygen concentrator on and the nasal cannula resting at her side. During an interview on 11/19/08 at 10:35 a.m., the day shift Charge Nurse (CN) stated the p.m.	F 157		

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F 157	Continued From page 3 shift had started routinely placing oxygen on the resident at bedtime. The CN stated the evening shift put the O2 on the resident and the day shift would then take the oxygen off when they assisted the resident to get up for the day. The CN stated the resident generally did not need O2 during the morning shift. She stated the resident needed it at times after breakfast. When asked why the p.m. shift had started placing the resident on oxygen at night, the CN stated because the resident's SpO2 levels would fall when she slept. When asked for more details the day CN suggested the surveyor talk to the p.m. CN. On 11/21/08 at 11:00 a.m., the DON provided a copy of the facility's Oxygen Administration Documentation Guidelines and Guidelines for Physician Notification of Change of Condition/Clinical Problems. The documentation guidelines instructed staff to evaluate and document, "[The] Resident's response, as related to the initiation of oxygen therapy and as needed [including]: Effectiveness of oxygen therapy, vital signs before and after therapy... Signs and Symptoms of hypoxia [including] increased rate of respirations or irregular respiratory patterns... Decreased lung sounds, adventitious sounds...Dyspnea... and Pallor, cyanosis. The Physician notification guidelines instructed staff to notify the physician, "Within one day to 72 hours... [of] more frequent or longer lasting episodes of dyspnea... even if responding to treatment. During a telephone call on 11/21/08 at 11:30 a.m., the resident's p.m. CN was interviewed regarding the documented increased use of oxygen at night. The LN stated that she had	F 157		

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F 157	Continued From page 4 recently started putting the resident "on a little oxygen at bedtime" to keep her oxygen levels from going down when she slept. The LN stated the resident had also started wheezing more at night. The LN indicated the resident's SpO2 levels and wheezing responded well to,"1 or 2 liters of oxygen." The LN was asked if her observations and actions were documented in the resident's chart (e.g. Nurse Progress Notes)? The LN stated she had only documented her observations and actions on the Treatment Sheets. When asked if the physician been notified of the resident's increased use of oxygen at night? The LN stated, as far as she was aware, the physician had not been notified of the increased O2 use.	F 157		
F 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164	F 164 **Resident Specific** **Resident # 4 is assisted to close his door during personal care times. The plan of care was updated as indicated.** **Other Residents** **IDT reviewed other residents, who are independent in care, to ensure personal privacy. No other concerns were identified.** **Facility Systems** **Direct care staff are educated to maintain resident's personal privacy during cares to include but not limited to, those who are independent with personal cares. Direct care staff re-education was provided for resident privacy and dignity. LN to include ongoing monitor during rounds.** **Monitor** **The DNS and/or designee will monitor LN round results, as well as complete rounds to**	

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F 164	Continued From page 5 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interviews, it was determined the facility had failed to ensure the personal privacy of a resident. This was true for 1 of 12 (#4) sampled residents. Findings include: Resident #4 was admitted to the facility with diagnoses of diabetes mellitus type two, amputation of legs bilateral, hypertension, and peripheral vascular disorder. The most recent significant change MDS dated 8/22/08 documented the resident; * had intact short and long term memory, * had modified independence for cognition, * required assistance of one for personal hygiene and dressing, * was incontinent of bowel and bladder. The resident's care plan, dated 3/16/08, for problem of, "Routine Care Needs related to unfamiliar environment, altered physiological status, bilateral BKA (below knee amputee) and weakness" with documented interventions of; * provide AM & PM care per facility P/P (policy and procedures), * 1 assist for oral hygiene, shaving, and grooming, * 1 assist with dressing in seasonally appropriate	F 164	**review residents for maintenance of personal privacy. Any concerns will be addressed immediately and discussed with the Performance Improvement (PI) committee as indicated. The PI committee may adjust frequency of the monitoring, as it deems appropriate.** **Date of Compliance** **December 26, 2008**	

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F 164	Continued From page 6 clothing, and * provide verbal cues as necessary. The resident also had a care plan for problem of, "Self Care Deficit: bathing/dressing/hygiene related to weakness and prosthesis LLE (Left Lower Extremity)" with documented interventions of; *provide AM & PM care per facility P/P, * assist with dressing in seasonally appropriate clothing, Minimum assist, * report to charge nurse any declines in resident's ADL performance, and * provide verbal cues as necessary. Resident #4 was observed on 11/18/08 from 9:00 a.m. until 9:10 a.m. from the hallway outside the room. The resident's door to the room was wide open so the resident could be observed. The resident was naked from the waist up, at the sink shaving, washing his face and brushing his teeth. During this time the following occurred; * 9:07 a.m.: The speech therapist pushed a female resident by the room with the door open in view of the resident, * 9:09 a.m.: Activity director stopped at the room and asked the resident if he "wanted to come to the TV room." The resident was still not dressed and doing self cares and did not want to go. The activity person left and did not close the door. The resident was still without clothes on. * 9:10 a.m.: A Therapy Aide came by the room and asked Resident #4 if he needed something, then advised him to use the call bell and proceeded to close the privacy curtain and door to the room to give the resident privacy. The resident did not request that the door be left open when she closed the door.	F 164		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 7 On 11/19/08 at 9:00 a.m. the resident was interviewed and when asked about the observation the day before and his privacy the resident did not have a problem with the door being open while doing morning cares. The resident did prefer that the door be closed throughout the day. The administrator and DON were informed of the observation 11/21/07 at 11:30 a.m.. No response was obtained.	F 164		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	F 225 **Resident Specific** **Resident # 9 incident report and investigation was completed during the survey. LN responsible for omission was coached regarding incident investigation and reporting procedures.** **Other Residents** **The LN management team reviewed other residents for missing incident investigations. No other residents concerns were identified.** **Facility Systems** **LN staff is educated to complete timely incident reports and thorough investigations. LN staff were re-educated on what constitutes an incident, as well as thorough and timely completion of reports.** **Monitor** **The DNS and/or designee will review 24-hour report and follow incident reporting, investigation, and reporting. Any concerns will be addressed immediately and discussed with the PI committee as**	

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F 225	Continued From page 8 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility did not ensure an investigation took place after a resident was injured by another resident's wheelchair. This affected 1 of 13 sampled residents (#9). The findings include: Resident #9 was admitted to the facility on 10/24/08 with the diagnoses of non-insulin dependent diabetes mellitus, developmental delay and hypertension. Resident #9's admission MDS assessment, dated 10/31/08, documented the following: * Both short-term and long-term memory problems * Moderately impaired cognitive skills for daily decision making Nurses Notes on 11/2/08 documented, "R[esident] appears to be dealing with room change well. C/O [complains of] ankle pain, states another R W/C [wheelchair] bumped it in hall. No witnesses." Review of the 11/08 I/A file showed no	F 225	**indicated. The PI committee may adjust frequency of the monitoring, as it deems appropriate.** **Date of Compliance** **December 26, 2008**	

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F 225	Continued From page 9 investigation was found for Resident #9's injury on 11/02/08. On 11/21/08 at 11:15 am, the DON and RN consultant were asked to provide the missing I/A. At 3:30 pm on 11/21/08, the Administrator provided an I/A for the event on 11/2/08, which had been completed on 11/21/08.	F 225		
F 252 SS=E	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure areas used for residents to relax in and entertain family in were homelike and uncluttered. This was true for 1 of 1 resident lounge on the 100 hall. The cluttered environment directly effected 2 random residents (#18 & 19) observed during the survey, and had the potential to effect all residents on the 100 hall who were not bed bound. The findings include: During the initial tour of the facility on 11/17/08 at 5:00 p.m., a small room (lounge) furnished with a television, radio, love seat, recliner and an easy chair was observed on the 100 hall. The room was approximately 15 feet in length by 12 feet in width. In addition to the regular furnishings, a Hoyer lift, wheelchair, and walker were stored randomly in the room. The LN accompanying the surveyor on the tour stated the room was used as a quiet area for residents who needed decreased	F 252	F 252 **Resident Specific** **Lifts and equipment were removed from the 100-hall alcove during survey.** **Other Residents** **The IDT completed center rounds with no other areas of clutter identified.** **Facility Systems** **Staff was educated on the need for an uncluttered, homelike environment to include but not limited to, appropriate equipment storage areas. IDT completes routine environmental rounds and room audits to maintain a homelike environment.** **Monitor** **The Executive Director (ED), DNS, and/or designee will complete rounds to monitor for appropriate equipment storage and a homelike environment. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust frequency of the monitoring, as it deems appropriate.** **Date of Compliance** **December 26, 2008**	

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F 252	Continued From page 10 stimulation and to give residents a private place to visit with guests. On 11/18/08 at 8:25 a.m., a sit to stand lift, and second walker were observed in the room, in addition to the regular furnishings and stored equipment observed on 11/17/08. On 11/18/08 at 9:15 a.m., random Resident #18 was observed sitting in her wheelchair in front of the television set in the lounge. The television was turned on and the resident sat quietly. The equipment observed at 8:25 a.m. remained in the lounge. This same resident was also observed on 11/19/08 at 11:00 am, resting in the recliner with soft music playing. The stored equipment remained in the room. On 11/19/08 at 2:35 p.m., Random Resident #19 was observed sitting in a wheelchair in the lounge. Soft music was playing. The resident's eyes were closed and she appeared to be napping. In addition to the regular furnishings, the Hoyer lift, and a walker, the room also contained a card table and two straight chairs. The card table was placed close to the entrance of the room and partially obstructed free movement to the television and love seat. On 11/19/08 at 2:45 p.m., the charge nurse was asked about the table and chairs. The charge nurse stated a resident's family had joined her for lunch that day and they were set up to eat in the lounge. On 11/20/08 at 10:00 a.m. the lounge was again observed. In addition to the regular furnishings and the equipment observed on 11/19/08 at 2:35 p.m., the card table remained in the room.	F 252		
F 280	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE	F 280	F 280	

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F 280 SS=D	Continued From page 11 CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interview, it was determined that the facility failed to ensure that a comprehensive care plan was developed to address problems of incontinence, catheter care, and oxygen therapy. This was true for 3 of 13 (#s 3, 4 and 7) sampled residents. Findings include: 1. Resident #4 was admitted to the facility with diagnoses of diabetes mellitus type two, amputation of legs bilateral, hypertension, and peripheral vascular disorder.	F 280	**Resident Specific** **Resident # 3, 4, & 7 care plan interventions were individualized and updated for changes.** **Other Residents** **The IDT reviewed other residents for like issues. Ongoing review will occur with quarterly care conferences and change of conditions.** **Facility Systems** **Resident care plans are established by the IDT upon admission and then reviewed quarterly or with a change of condition. The plan of care is established based upon assessment and is maintained to resident current status. LN staff were re-educated regarding updating of care plans to included but not limited to, resident elimination changes, indwelling catheter changes, and respiratory status monitoring parameters with the use of oxygen.** **Monitor** **The DNS and/or designee will review care plans to ensure completeness and accuracy. Utilization of the 24-hour report allows resident changes to be communicated and care plan updates to be validated. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust frequency of the monitoring, as it deems appropriate.** **Date of Compliance** **December 26, 2008**	

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The most recent significant change MDS, dated 8/22/08, documented the resident;
* had intact short and long term memory,
* had modified independence for cognition,
* required assistance of one for personal hygiene and dressing,
* was incontinent of bowel and bladder,
* the resident was coded as having "any scheduled toileting plan."

Resident #4's care plan, developed 9/28/08, listed a problem of "Incontinence, stress related to urge/stress" and had a goal of "will be clean, dry & free of skin breakdown." The interventions for this goal were;
* report areas of skin redness or breakdown,
* provide incontinence protection briefs,
* document # times incontinent per shift, and
* assist with toileting each AM, before/after meals, and at bedtime, provide incontinence care after each incontinent episode.

A care conference was held on the resident on 10/22/08. The "Resident Care Conference Outline" form used to document the conference lacked documentation that the care plan was reviewed.

Resident #4 was interviewed 11/19/08 at 9:10 a.m., and when questioned about incontinence the resident stated that he required a mechanical lift to transfer and could not get to the bathroom. The resident had lost both of his lower extremities and could no longer stand to transfer to the toilet. He preferred to not use a urinal. The resident, since readmission after losing the lower right extremity, indicated a preference to use incontinence pads and be changed. The resident was hopeful when he received the bilateral lower

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F 280	Continued From page 13 leg prosthesis that he could improve his continence of bowel and bladder. On 11/20/08 at 2:15 p.m. the MDS coordinator was interviewed about the resident's incontinence and the resident's preference to be checked and changed. The MDS coordinator indicated the resident was due for a quarterly assessment and the wishes of the resident would be incorporated into the care plan update. 2. Resident #3 was admitted to the facility on 10/22/08 with the diagnoses of spinal cord injury, constipation, neuropathy, and muscle spasms. Resident #3's admission MDS assessment, dated 10/22/08, documented the following: * Short-term memory loss * Modified independence for cognitive skills for daily decision making * Indwelling catheter. Resident #3's care plan, dated 11/4/08, contained the problem, "Foley Catheter R/T [related to] Neurogenic Bladder, C-4 quad[raplegic]." One of the approaches documented, "Change Foley Q 6 wks and PRN [Change catheter every 6 weeks and as needed]." Physician Telephone Orders for 11/9/08 documented, "Continue indwelling catheter and change q 30 days." On 11/20/08 at 10:05 am, the DON was interviewed concerning Resident #3's care plan for a change of Foley catheter every 6 weeks. She confirmed that the resident's Foley catheter should be changed every 30 days and stated, "I will revise it."	F 280		

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F 280	Continued From page 14 3. Resident #7 was admitted to the facility on 7/3/08 with diagnoses of dementia, chronic obstructive pulmonary disease, hypertension, and type 2 insulin dependent diabetes. Resident #7's most recent quarterly MDS assessment, dated 9/19/08, documented the following: * Short-term and long-term memory problems. * Moderately impaired cognitives skills for daily decision making. * Extensive Assistance needed with dressing, toileting, and hygiene. Resident #7s Physician's Recapitulation (Recap) Orders for November 2008, included: * "O2 PRN to keep sats > 90%. [Oxygen as needed to keep SpO2 greater than 90%]" No frequency of O2 checks, or dosage and titration parameters were given. * "Albuterol Ipratropium [Duoneb] 3 ml solution inhalation 4 X daily PRN [3 milliliters 4 times per day]." * "Roxanol (Morphine Sulfate) 0.5 ml - 1 ml PO [By Mouth] PRN ... air hunger." A Care Plan Update form, dated 10/17/08, included the problem "Risk for airway obstruction. Risk for infection [related to] possible choking on liquids." The goals for the problem were, "Res[ident] will remain free of airway obstruction. Res[ident] will remain free from infection/URI [Upper Respiratory Infection]." The interventions included: * "Monitor [vital signs], increased temperature, decreased sats [SpO2]." * "02 per order. Keep sats above 90%." * "Breathing treatment as ordered QID [4 times per day] for pneumonia prevention."	F 280		

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F 280	Continued From page 15 The Resident's care plan, dated 8/19/08, also contained the problem, "Cardiac Output, Altered [related to] HTN [Hypertension]." The interventions for this problem included instructions for nursing staff to, "Report fatigue, weakness, cool, pale, clammy skin, blue lips or nails..." Resident #7's Medication Administration Records (MARs), Treatment Records, Nurse Progress Notes, and Vital Sign Flow Sheets, dated 9/1/08 through 11/18/08, documented the resident's SpO2 was monitored at least one time per day between 9/1/08 and 11/5/08. The SpO2s ranged from a low of 90% to 99%. Beginning on 11/5/08 the SpO2s were also checked every evening and throughout the night. The SPO2s ranged from 87% to 99%. The Treatment Record documented the resident was placed on O2 every night starting on 11/5/08. The recorded liter (L) flow of the 02 administered PRN varied greatly and showed no consistent correlation to SpO2 levels. Examples include: - On the night of 11/5/08, SpO2 levels were recorded twice (no times given). The first reading was documented as 90% on RA (Room Air), the second reading was documented as 92 % on 1L of O2. - On the night of 11/6/08, SpO2 levels were recorded twice (no times given). The first reading was documented as 98% on 2L, the second reading was documented as 95% on 2.5L. - On the night of 11/7/08, SpO2 levels were recorded three times (no specific times documented). The first and second times were documented as 90 % on 2L, the third was 94% on 2L.	F 280		

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F 280	Continued From page 16 - On the night of 11/8/08, SpO2 levels were recorded twice (no times given). The first reading was documented as 90% on 2L, the second reading was documented as 96% on 2L. - On the night of 11/9/08, SpO2 levels were recorded three times (no specific times documented). The first time the SpO2 was documented as 87% and the O2 liter flow was 2.5 %, the second time it was recorded as 99% and the liter flow 3L, the third was 97% with the liter flow recorded as 2L. The SpO2/O2 administration findings were similar for 11/10/08 thru 11/18/08. On 11/18/08 at 7:05 a.m., Resident #7 was observed sleeping in bed. The O2 concentrator at her bedside was running. It was set at 2L. A nasal cannula was connected to the concentrator but rested at the resident's side rather than in her nose. At 7:30 a.m., on 11/18/08, Resident #7 continued to sleep with the O2 concentrator on and the nasal cannula resting at her side. During an observation of morning cares on 11/18/08 at 8:15 a.m., a CNA entered Resident #7's room, woke the resident, and explained to the resident that she would be helping the resident to get dressed. The CNA reached over and placed the nasal cannula in the resident's nose. After providing pericare and dressing the resident, the CNA assisted the resident to come to a sitting position, transfer to a wheel chair, and then moved the resident to the sink to wash her face and hands. During the move to the sink, the CNA removed the O2 cannula from the resident's nose because the O2 tubing was too short to stretch from the O2 concentrator to the sink. The resident was observed to become slightly short of breath, and have occasional deep, short coughs with the increased activity. When the resident was	F 280		

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F 280	Continued From page 17 sitting in front of the sink, a LN entered the room and checked Resident #7's blood sugar. After checking the resident's blood sugar the LN placed a nasal cannula on the resident. The nasal cannula was attached to a portable O2 tank on the back of the resident's wheel chair. The LN then filled a hand held nebulizer with a liquid solution and handed it to the resident. The resident was short of breath and her hands were shaking. The CNA commented to the LN that the resident was found with her O2 off when the CNA entered the room that morning. The CNA stated the resident was, "Dusky." The LN left the room, after the breathing treatment, without assessing the resident (e.g. lung sounds) or requesting the residents O2 level or vital signs be checked. The resident's shortness of breath did improve after the breathing treatment. On 11/19/08 at 9:45 a.m., Resident #7 was observed sitting in her wheel chair in the activity room. She did not have O2 on. Two CNAs approached the resident and quietly asked her if she needed to go to the bathroom. The resident acknowledged that she did, the CNAs wheeled her to the bathroom and transferred her to the toilet. After the resident used the toilet the CNAs assisted her to stand, provided peri-care, and then transferred her back to the wheelchair. After the transfer back to her wheel chair, the resident's hands were shaky, her fingers and lips had become slightly dusky, and she had an occasional deep, short cough. The CNAs placed a nasal cannula, which was attached to the portable O2 tank on the back of the resident's wheel chair, in the resident's nose and turned the O2 on. The CNAs moved the resident's wheel chair to the door to take her back to the activity room. The surveyor stopped the CNAs and asked	F 280		

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them to check the resident's O2 level. One CNA left the room and returned with a pulse oximeter and the day shift LN charge nurse (CN). The CNA checked the resident's SpO2 which read 84%. The CN did not assess the resident (e.g. lung sounds) or request that a set of vital signs be taken. The charge nurse did ask the CNAs to recheck the resident's SpO2 in, "5 minutes." The resident was then taken back to the activity room. The resident was again observed at 10:15 on 11/19/08. The resident was no longer shaky or dusky. The CN reported the resident's SpO2 was 95% when the CNAs rechecked it. The resident continued to receive O2 at 2 liters.

During an interview on 11/19/08 at 10:35 a.m., the day shift Charge Nurse (CN) stated the p.m. shift had started routinely placing O2 on the resident at bedtime because the resident's O2 levels would go down at night. The day shift CN stated the day shift CNAs would then take the O2 off when they assisted the resident to get up for the day. The CN stated they did not generally check the resident's SPO2s until after breakfast and the resident usually did not require O2 during the day.

11/20/08 at 8:00 a.m., Resident #7 was observed waiting for breakfast in the activity/dining room. The resident was sitting in her wheel chair and did not have O2 on. The resident was not short of breath, shaky, or dusky.

During an observation at 9:05 a.m. on 11/20/08, Resident # 7 was being assisted to eat breakfast by the CN who sat at the resident's left hand side. The resident did not have O2 on. The resident held a coffee cup in her hand and the CN was giving her a bite of food. When the resident lifted

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F 280	Continued From page 19	F 280		

the coffee cup to her mouth the resident's hands were shaky, pale, and dusky. The resident's lips were also dusky with a pale halo around their circumference. The CN cued the resident to take another bite of food and then turned to a second resident sitting at the same table to verbally cue that resident to eat. Because of the circumoral pallor and cyanosis, as well as the shaky/dusky hands, the surveyor asked the CN to check the resident's SpO2 level. The CN commented staff generally checked the SpO2 after breakfast because staff did not like to interrupt the resident's meal. The surveyor repeated the request and the CN pulled the oximeter machine to the resident to check the SpO2. The SpO2 read 74% and the CN placed the resident on 3 liters of O2 by nasal cannula. It took approximately 15 minutes for the Resident #7's SpO2 to go above 90%. At 9:20 a.m., the resident's SpO2 was 97%. The resident's hands were a light pink and she was no longer shaky. The resident's lips were still slightly dusky put the circumoral pallor was gone. The CN turned the O2 level down to 1.5 liters and took the resident to her room to assess her lung sounds and take vital signs.

On 11/20/08 at 11:30 a.m. the DON was interviewed regarding the resident's Care Plan, SpO2 checks, and O2 use. The DON indicated that the specifics for O2 dosing should be covered in physician's orders. She stated the facility had protocols which gave staff guidelines for monitoring SpO2 levels and responding to episodes of hypoxia. The DON provided a copy of the facility's O2 Administration Guidelines. The guidelines instructed staff to evaluate and document, "[The] Resident's response, as related to the initiation of O2 therapy and as needed

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F 280	Continued From page 20 [including]: Effectiveness of O2 therapy, vital signs before and after therapy... Signs and Symptoms of hypoxia [including] increased rate of respirations or irregular respiratory patterns... Decreased lung sounds, adventitious sounds...Dyspnea... and Pallor, cyanosis. The guidelines did not contain specific instructions for frequency of SPO2 checks or rechecks. The guidelines also did not offer guidelines for titrating O2 levels. During a telephone call on 11/21/08 at 11:30 a.m., the p.m. CN was interviewed regarding the increased use of O2 at night. The p.m. CN stated that she had recently started putting the resident "on a little O2 at bedtime" to keep her O2 levels from going down when she slept. The LN stated the resident had also started wheezing more at night. The LN indicated the resident's SpO2 levels and wheezing responded well to,"1 or 2 liters of O2." Resident #7's Care Plan was not updated or individualized to address how frequently the resident's SPO2 should be checked, when the SPO2 should be rechecked, the need to use O2 at night to keep the resident's O2 levels above 90%, or how/when the nurses were to titrate O2 levels. This resulted in inconsistent monitoring of the residents O2 levels and inconsistent PRN O2 use.	F 280		
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281	F 281 **Resident Specific** **Resident # 16's Physician Recapitulation Orders were updated to electronically include the order change to Depakote. Resident # 20's Medication Administration Record (MAR) reflects Advair discus order changed to include "rinse & spit after inhaling".**	

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F 281	Continued From page 21 Based on observation, staff interview and record review, it was determined that the facility failed to ensure that medication administration and physician recapitulation orders meet professional standards of quality. This was true for 2 of 6 (#'s 16 & 20) residents observed during medication passes. Findings include: 1. During a medication pass observation on 11/18/08 at 9:10 a.m., Random Resident #16 received two capsules of Depakote (Valproic Acid) 125 mg [milligrams], totaling 250 mg. The current Physician's Recapitulated Orders (Recap), dated 11/1/08 - 11/30/2008, documented the resident was to receive "Depakene sprinkles 125 mg q [every] a.m. [morning]." Further review of the resident's medical record revealed a Physician's Telephone Order, dated 8/21/08, which changed the a.m. dose of Depakene 125 mg to Depakote 250 mg. However, neither the Recap Orders for September, October, nor November 2008 were updated to reflect the 8/21/08 change in the Depakote (Valproic Acid) order. All three Recap Orders continued to list, "Depakene sprinkles 125 mg q [every] a.m. [morning]." The Medication Administration Records (MARs) for September 2008 thru November 2008, contained hand written edits for the Depakene sprinkles which crossed out 125 mg, and changed it to 250 mg. On 11/20/08 at 8:45 a.m., the administrator and medical records director (MRD) were interviewed regarding the process for updating the recap orders and MARS. The MRD stated that at the end of each month she reviewed all new orders received during the month, updated the recap	F 281	**Other Residents** The LN management team and Medical Records (MR) reviewed all Physician Recapitulation Orders for accuracy updating as indicated. They also reviewed all residents with orders for steroid inhalers adding directives to the MAR to "rinse and spit after inhaling". Observations of LN staff were made to monitor for professional standards to include but not limited to, resident rinsing mouth after use of a steroid inhaler. **Facility Systems** LN staff complete skills checks for use of inhalers during orientation, annully, and as needed thereafter. LN re-education was completed for inhalers to include but not limited to, rinsing after steroid inhaler use. For residents with steroid inhalers the MAR now states to "rinse & spit after inhaling". **Monitor** MR reviews steroid inhaler orders to include "rinse & spit after inhaling". Staff Development Coordinator (SDC) reviews LN staff steroid inhaler use techniques. The DNS and/or designee will perform periodic review for sustained implementation. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust frequency of the monitoring, as it deems appropriate. **Date of Compliance** December 26, 2008	

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F 281	Continued From page 22 orders to reflect any changes that had not been transferred over, and then printed the new recap orders and MARs for the month. The MRD stated the printed MARs were computer generated from the recap orders. During the interview, the administrator stated that after the new recap orders and MARs were sent to the nursing unit, the LNs (usually the charge nurses) double checked the new physician's orders, against the recap orders and the MARs, prior to putting the MARs into the medication book for the new month. During the same interview the MRD was asked how the order change was missed on the three months of recaps. The MRD stated she had been on medical leave and out of the facility for several weeks. The MRD stated the order change occurred when she was on leave. She stated the order change was noted by the LNs, as evidence by the handwritten edits on the MARs, but the change was not carried over to the recap orders. The MRD stated the LNs did not notify her of the the ongoing error on the recap orders or the need to modify the printed MARs. The failure to carry the new physician's order onto the recap orders, which generated the printed MARS, put the resident at risk of receiving the wrong dose of Valproic Acid. The potential for error continued for three consecutive months when the nurses did not identify the discrepancy in their monthly review of the physician's current orders, recap orders, and MARs. 2. During a medication pass observation on 11/18/08 at 3:50 p.m., Random Resident #20 was observed watching television (TV) in the activity room on the 100 hall. The resident was	F 281		

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F 281	Continued From page 23 approached by an LN passing medications. The LN handed the resident a small cup of water and a plastic medication cup with a pill in it. The resident swallowed the pill and kept the cup of water in her hand. The LN then pumped the trigger on a discus of Advair 250/50 and handed the discus to the resident. The resident inhaled the medication and handed the discus back to the LN. The nurse and the resident visited for a moment and the nurse left the resident to continue passing medications. The LN did not cue the resident to rinse her mouth prior to leaving. After the nurse left, the resident set the cup of water down on a table next to her and turned back to watch TV. The resident did not rinse her mouth after using the Advair. During an interview on 11/21/08 at 2:30 p.m. a LN, observed standing by the medication cart on the 100 hall, was asked what their post administration proceedures were for Advair and similar inhaled medications. The LN stated the medication could cause a yeast infection and residents should be encouraged to, "Rinse and spit," after inhaling the medication. The manufacturers guidelines for the use of Advair, under the HIGHLIGHTS OF PRESCRIBING INFORMATION, explained that Advair contained corticosteroids and cautioned, "Localized infections: Candida albicans infection of the mouth and throat may occur. Monitor patients periodically for signs of adverse effects on the oral cavity. Advise patients to rinse the mouth following inhalation."	F 281		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain	F 309	**F 309** **Resident Specific** **The LN management team reviewed resident #'s 7, 9, & 10 for clear**	

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F 309	Continued From page 24 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined that the facility had failed to identify, treat and follow the facility policy and protocols for hypoglycemia resulting in residents potentially suffering harm from hypoglycemic episodes. This was true for 3 of 13 (#s 7, 9 and 10) sampled residents. Findings include: 1. Resident #10 was admitted to the facility on 1/20/03 with diagnoses of diabetes mellitus type 2, mitral/aortic stenosis, benign prostatic hypertrophy without urinary obstruction and Klinefelter's syndrome. The most recent quarterly MDS assessment, dated 10/1/08, documented: * the resident's short and long term memory was good, * the resident had some moderate impairment with decision making skills, * the resident was independent with ADL skills, and * the resident was continent of bowel and bladder. Review of the facility Incident and Accident reports indicated the resident had a fall in the shower on 11/6/08 at 9:50 p.m.. Review of the incident revealed the resident's blood glucose was 29 milligrams per deciliter (mg/dl). The	F 309	**identification of hypoglycemia directives. The plan of care and orders were updated as indicated.** **Other Residents** **LN team reviewed other residents who have a potential of hypoglycemia. Physicians were notified, orders received, and plans of care updated as indicated.** **Facility Systems** **The LN staff is educated to policies for hypoglycemic management to include but not limited to, parameters and sugared drink use followed with protein/carbohydrate food. LN staff re-education was provided for hypoglycemic management.** **Monitor** **The DNS and/or designee will perform periodic review for monitoring of hypoglycemia management. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust frequency of the monitoring, as it deems appropriate.** **Date of Compliance** **December 26, 2008**	

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F 309	Continued From page 25 resident was given 1 gram of glucagon and was transported to the hospital emergency room. The resident was "poorly responsive" at the emergency room. The resident was treated at the hospital, stabilized and discharged back to the facility on 11/7/08 at 12:04 a.m.. The discharge instructions were for the staff to, "check the patient blood sugar twice tonight and again before breakfast" and the staff were to "use oral glucose if RBS [random blood sugar] less than 60 [mg/dl]. or feed the patient if he is able to feed himself." The nursing staff checked the resident throughout the night 11/7/08 and the RBS results and what the resident received were; * 1:00 a.m. - 78 mg/dl - 120cc (cubic centimeter) shake given * 2:00 a.m. - 124 mg/dl - banana and 120cc whole milk * 3:00 a.m. - 54 mg/dl - 240cc shake (med pass) * 3:15 a.m. - 218 mg/dl * 4:30 a.m. - 115 mg/dl - banana and 120cc shake. The facility policy and procedure number PRO 64203 dated 10/31/07 for Hypoglycemia was reviewed. The policy under "Rationale" stated one of the signs and symptoms of hypoglycemia was a "Blood sugar less than 70 mg/dl unless otherwise indicated by physician." The policy specified under "Equipment/Supplies" to give "one of the following sugared drinks"; - Glucagon (unconscious resident) with physician's order, - 1/3 bottle of instant glucose (semi-conscious resident),	F 309		

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F 309	Continued From page 26 - 4 ounces fruit juice other than tomato (conscious resident), - 6 ounces soda pop (conscious resident) It also specified one of the following foods; - Buttered toast, - 2 crackers and 1 ounce cheese, - one serving of ice cream, - one carton (1/2 pint) of milk. Resident #10's medical record was reviewed for additional times when he had a hypoglycemic episode. The following additional times were; -7/31/08 at 6:00 p.m. - RBS 55 mg/dl - gave 2 milkshakes and ate dinner. -8/2/08 at 6:00 p.m. - RBS 51 mg/dl - provided with 2 milkshakes, ate sandwich soup for dinner. -8/28/08 at a.m. - RBS 54 mg/dl - Banana and milk given, -8/29/08 at 10:00 p.m. - RBS 46 mg/dl - ate a banana, sandwich, and drank milk and milkshake. -9/10/08 at 10:00 p.m. RBS 43 mg/dl - Mighty Shake given. The DON was interviewed 11/21/08 at 11:00 a.m. about the facility staff not following policy for hypoglycemia and no further information was received. 2. Resident #9 was admitted to the facility on 10/24/08 with the diagnoses of non-insulin dependent diabetes mellitus, developmental delay and hypertension. Resident #9's admission MDS assessment, dated 10/31/08, documented the following: * Both short-term and long-term memory	F 309		

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F 309	Continued From page 27 problems * Moderately impaired cognitive skills for daily decision making * Able to be understood through speech Nurses Notes (NN) on 11/3/08 documented, "Resident discovered to be non-responsive in room. BG [blood glucose] 15. Injected 1 ml IM of glucogon (sic) [Injected one milliliter intramuscular of glucagon]. Resident started responding to voices. BG increased to 44, milk and shake given, R[esident] talking to staff. On call (physician) notified, stated, 'This is periodically normal for resident.' No changes to orders. Advise to monitor resident closely at night for drop in BG's." Resident #9's Blood Glucose Monitoring Worksheet documented that the resident experienced another hypoglycemic episode on 11/20/08 at 12:30 am, with an RBS of 27 mg/dl. The physician was notified and the resident was rechecked at 1:00 am with an RBS of 94 mg/dl. No NN concerning this incident were found in the resident's record. On 11/20/08 at 8:05 am, the DON was asked what the facility policy was concerning hypoglycemic episodes. She replied, "We always call the doctor if it is below 60." When asked for a copy of the facility policy, she stated, " It is in one of my grade eight manuals," and agreed to provide a copy to the surveyor. At 8:15 am on 11/20/08, a LN medication nurse was asked what to do in a hypoglycemic episode. She replied, "Below 70 call the doctor, give protein shakes, and check in an half an hour."	F 309		

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F 309	Continued From page 28 After providing it to the surveyor, facility policy and procedure number PRO 64203, dated 10/31/07, for Hypoglycemia was reviewed. The policy under "Rationale" stated one of the signs and symptoms of hypoglycemia was a "Blood sugar less than 70 mg/dl unless otherwise indicated by physician." The policy specified under "Equipment/Supplies" to give "one of the following sugared drinks"; - Glucagon (unconscious resident) with physician's order, - 1/3 bottle of instant glucose (semi-conscious resident), - 4 ounces fruit juice other than tomato (conscious resident), - 6 ounces soda pop (conscious resident) It also specified one of the following foods; - Buttered toast, - 2 crackers and 1 ounce cheese, - one serving of ice cream, - one carton (1/2 pint) of milk. On 11/21/08 at 11:00 am, the DON and nurse consultant were interviewed concerning Resident #9 being given a protein shake instead of a sugared drink during a hypoglycemic episode. The DON stated that the protein shake was a sugared drink. Then the DON was shown the facility protocol which only glucagon, instant glucose, fruit juice, and soda pop were listed as sugared drinks. No further information was provided by the facility. * Resident #7 was admitted to the facility on 7/3/08, with diagnoses of dementia, chronic obstructive pulmonary disease, hypertension, and type 2 diabetes.	F 309		

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F 309	Continued From page 29 The resident's most recent quarterly MDS assessment, dated 10/4/08, documented: * Short and long term memory problems * Moderate impairment with decision making skills * Diagnosis of Diabetes Mellitus * Injections 7 days per week Resident #7's Physician Recapitulation Orders, dated 11/1/2008 - 11/30/2008, included the following orders for diabetic management: * Lantuss Insulin 8 units subcutaneous injection daily at bedtime. * Metformin 1000 milligrams by mouth two times per day. * Blood glucose (BG) BID [twice per day]. * Sliding Scale Insulin coverage for BG over 150. * Low Concentrated Sweets diet. The resident's care plan, dated 10/29/08, listed the problem, "Potential for Hyper/Hypoglycemia r/t [related to] IDDM [Insulin Dependent Diabetes Mellitus." The goal for the problem was, "BS [Blood Sugar] will remain 80 - 150." Interventions included, "BS q [every] a.m. & p.m... Monitor for s/s [signs and symptoms] of hyper/hypoglycemia." The care plan did not specify what actions staff were to take to respond to episodes of hyper/hypoglycemia. During an interview on 11/21/08 at 11:00 a.m., the DON was asked if residents' care plans should outline how staff were to respond to hypoglycemic episodes. The DON indicated that resident care plans did not specifically address response to either hyper or hypoglycemia because the response was covered in the individual residents' physician orders and/or the facility's protocols. The DON stated the protocol	F 309		

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F 309	Continued From page 30 was based on current ADA (American Diabetic Association) recommendations. The facility's policy and procedure (Protocol) number PRO 64203, dated 10/31/07, was reviewed. The protocol discussed hyper/hypoglycemia and defined hypoglycemia as a, "Blood sugar less than 70 mg/dl unless otherwise indicated by physician." The protocol definitions and instructions were found to be in compliance with 2008 ADA guidelines for health care practitioners. Under "Equipment/Supplies," the protocol instructed staff to respond to incidents of hypoglycemia by giving, "One of the following sugared drinks"; - Glucagon (unconscious resident) with physician's order - 1/3 bottle of instant glucose (semi-conscious resident) - 4 ounces fruit juice other than tomato (conscious resident) - 6 ounces soda pop (conscious resident) The protocol also specified one of the following protein/carbohydrate foods should be given; - Buttered toast - 2 crackers and 1 ounce cheese - One serving of ice cream - One carton (1/2 pint) of milk Resident #7's Medication Administration Records (MARs) and Nurse Progress Notes, dated 9/1/08 through 11/20/08, were reviewed for the BID BG levels. The MARs documented episodes of hypoglycemia on 9/1/08 and 10/21/08: * On 9/1/08, the MAR recorded the resident's p.m. BG as 60. Neither the MAR nor the Nurse	F 309		

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F 309	Continued From page 31 Progress Notes recorded if, or how, nursing staff responded to the low blood sugar. In addition, the notes did not record a repeat blood sugar check. * On 10/21/08, the MAR recorded the resident's a.m. BG as 66. The Nurses notes stated, "BS [BG] this a.m. 66... juice [increased] to 106." Neither the MAR nor the Nurse Progress Notes indicated the juice (a sugared drink) was followed by a protein/carbohydrate food as specified in the facility's protocol and recommended by the ADA.	F 309		
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to ensure residents were protected from hazards by improperly storing nail polish remover, allowing a heater cover to have a sharp, protruding edge, and by a resident room fire containment door failing to fully close. This potentially affected all cognitively impaired ambulatory residents using the Tuscany dining room, all ambulatory residents using the hall outside of the entrance to the Huckleberry dining room, and all residents of the 300 unit. The findings include: 1. On 11/18/08 at 11:00 am, a cabinet without a locking device, above the sink in the Tuscany dining room, was opened by the surveyor. Stored	F 323	F 323 **Resident Specific** **No specific numbered residents were identified.** **As noted in the 2567, the following items were correct during survey: the nail polish remover was secured in a locked area, the heater cover was repaired, and the door for room 309 adjusted to close properly.** **Other Residents** **The IDT made rounds to identify other potential hazards. All areas of concern were corrected.** **Facility Systems** **Staff is educated to report any potential hazards or items in need of repair. Staff re-education was provided to include but not limited to, securing of items identified as "harmful" if ingested, reporting sharp edges on heaters, and doors that do not close properly.** **Monitor** **The ED, Maintenance Director, and/or designee will perform periodic rounds to**	

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F 323	Continued From page 32 on a shelf at eye level was one 12-ounce bottle of nail polish remover with the warning label, "Harmful if ingested." An eight-ounce bottle of "Dip it Off" nail polish remover with the warning label, "Harmful if taken internally," was found on the same shelf. On 11/18/08 at 4:15 pm, the administrator was made aware of the improperly stored nail polish remover. He stated that he would take care of it. Later, the administrator was observed at the cabinet in the Tuscany dining room. 2. On 11/19/08 at 2:35 pm, a heater cover in the hallway outside of the entrance to the Huckleberry dining room was observed to have a sharp, protruding edge at its corner. This edge was 2-3 inches off the floor and could have potentially caused injury to a resident's foot. On 11/20/08 at 11:30 am, the administrator was made aware of the sharp corner of the heater cover. He indicated it would be taken care of. Later, the administrator showed the surveyor that the heater cover had been repaired. 3. During observation of morning cares on 11/18/08 at 7:55 a.m., when leaving room 309 the door could not be closed. The upper portion was against the door jam and had to be lifted to close. The door was a fire door for room 309 and 300 hallway. Two CNAs were questioned and both stated the door had been loose for several days. The maintenance staff were walking by the room at 8 a.m. and the surveyor informed them about the problem with closing of the door and they proceeded to fix the problem.	F 323	**monitor for safety issues not previously reported. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust frequency of the monitoring, as it deems appropriate.** **Date of Compliance** **December 26, 2008**	
F 328	483.25(k) SPECIAL NEEDS	F 328	**F 328**	

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F 328 SS=D	Continued From page 33 The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to: Ensure that PRN (as needed) oxygen orders: 1. Were well defined. 2. Set guidelines for prn oxygen titration. 3. Were followed as prescribed by residents' physicians. Ensure that SpO2 (Pulse Oximetry) and Pulmonary Toileting orders: 1. Prescribe the frequency of SpO2 checks. 2. Were followed as prescribed by the residents' physicians. This affected 3 of 4 sampled residents reviewed for oxygen/respiratory treatment (#s 6,7 & 12) . 1. Resident #7 was admitted to the facility on 7/3/08 with diagnoses of dementia, chronic obstructive pulmonary disease, hypertension, and type 2 insulin dependent diabetes. Resident #7's most recent quarterly MDS assessment, dated 9/19/08, documented the following:	F 328	**Resident Specific** Resident # 6, 7, & 12's physicians were notified regarding oxygen requirements. The plan of care and orders were updated as indicated. **Other Residents** The LN management team reviewed other residents with oxygen needs. Physicians were notified, orders received, and plans of care updated as indicated. **Facility Systems** LN staff are educated to center policies regarding oxygen therapy management to include but not limited to, order clarification, titration guidelines, pulmonary toilet documentation, monitor for implementation at the bedside, and indication of oxygen saturation recording and follow-up. LN staff re-education was provided, as well as, review of resident records with new/change in oxygen orders and plans of care to monitor for a complete process. **Monitor** The DNS and/or designee will perform periodic review for monitoring of oxygen therapy management. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust frequency of the monitoring, as it deems appropriate. **Date of Compliance** December 26, 2008	

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F 328	Continued From page 34 * Short-term and long-term memory problems. * Moderately impaired cognitives skills for daily decision making. * Extensive Assistance needed with dressing, toileting, and hygiene. No specialized treatments or therapies (i.e. oxygen therapy) were indicated on the 9/19/08 MDS. Resident #7s Physician's Recapitulation (Recap) Orders for November 2008, included: * "O2 PRN to keep sats > 90%. [Oxygen as needed to keep SpO2 greater than 90%]" No frequency of O2 checks, or dosage and titration parameters were given. * "Albuterol Ipratropium [Duoneb] 3 ml solution inhalation 4 X daily PRN [3 milliliters 4 times per day]." PRN symptoms were not defined (e.g. shortness of breath, dyspnea, wheezing, other respiratory distress). * "Roxanol (Morphine Sulfate) 0.5 ml - 1 ml PO [By Mouth] PRN ... air hunger." A Care Plan Update form, dated 10/17/08, included the problem "Risk for airway obstruction. Risk for infection [related to] possible choking on liquids." The goals for the problem were, "Res[ident] will remain free of airway obstruction. Res[ident] will remain free from infection/URI [Upper Respiratory Infection]." The interventions included: * "Monitor [vital signs], increased temperature, decreased sats [SpO2]." * "02 per order. Keep sats above 90%." * "Breathing treatment as ordered QID [4 times per day] for pneumonia prevention." The Resident's care plan, dated 8/19/08, also	F 328		

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F 328	Continued From page 35 contained the problem, "Cardiac Output, Altered [related to] HTN [Hypertension]." The interventions for this problem included instructions for nursing staff to, "Report fatigue, weakness, cool, pale, clammy skin, blue lips or nails..." Resident #7's Medication Administration Records [MARs], Treatment Records, Nurse Progress Notes, and Vital Sign Flow Sheets, dated 9/1/08 through 11/18/08, were reviewed for SpO2 monitoring and prn use of breathing treatments, oxygen, and Roxanol. * September 2008 - October 2008 The Treatment Records and/or Vital Sign Flow Sheets documented the resident's SpO2 was monitored at least one time per day. The SpO2 ranged from a low of 90% to 99%. The MARs documented the resident received no Roxanol during September and October, but received a daily Duoneb breathing treatments at 8:00 a.m., 1200 noon, 4:00 p.m., and 8:00 p.m. in September and October. The MARs, Treatment Records, and Nurses Notes for those months did not document episodes of hypoxemia or respiratory distress related to the administration of the breathing treatments. * November 2008 The Treatment Records and/or Vital Sign Flow Sheets for 11/08 documented the resident's SpO2 was monitored at least one time per day between 11/1/08 and 11/18/08 and every night between 11/5/08 and 11/18/08. The SpO2 ranged from a low of 87% to a high of 99%. The MARs documented the resident received no Roxanol in 11/08, but continued to receive daily Duoneb treatments at 8:00 a.m., 1200 noon, 4:00 p.m.,	F 328		

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F 328	Continued From page 36 and 8:00 p.m. in The Treatment Record for 11/08, documented Resident #7 was placed on oxygen every night starting 11/5/08. The recorded liter (L) flow of the 02 administered varied greatly and showed no consistent correlation to SpO2 levels. Examples include: - On the night of 11/5/08, SP02 levels were recorded twice (no times given). The first reading was documented as 90% on RA (room air), the second reading was documented as 92% on 1L of O2. - On the night of 11/6/08, SP02 levels were recorded twice (no times given). The first reading was documented as 98% on 2L, the second reading was documented as 95% on 2.5L. - On the night of 11/7/08, SpO2 levels were recorded three times (no specific times documented). The first and second times were documented as 90% on 2L, the third was 94% on 2L. - On the night of 11/8/08, SP02 levels were recorded twice (no times given). The first reading was documented as 90% on 2L, the second reading was documented as 96% on 2L. - On the night of 11/9/08, SpO2 levels were recorded three times (no specific times documented). The first time the SpO2 was documented as 87% and the O2 liter flow was 2.5%, the second time it was recorded as 99% and the liter flow 3L, the third was 97% with the liter flow recorded as 2L. The SpO2/O2 administration findings were similar for 11/10/08 thru 11/18/08. The Nurse Progress Notes for 10/30/08 - 11/18/08, were general in nature. The notes did not address abnormal SpO2 levels or the	F 328		

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F 328	Continued From page 37	F 328		

increase in the night time use of oxygen. The nurses notes also did not document physician notification of the increased need for night time oxygen since 11/05/08.

On 11/18/08 at 7:05 a.m., Resident #7 was observed sleeping in bed. The oxygen concentrator at her bedside was running. A nasal cannula was connected to the concentrator but rested at the resident's side rather than in her nose. At 7:30 a.m., on 11/18/08, Resident #7 continued to sleep with the Oxygen concentrator on and the nasal cannula resting at her side.

During an observation of morning cares, on 11/18/08 at 8:15 a.m., a CNA entered Resident #7's room, woke the resident, and explained to the resident that she would be helping the resident to get dressed. The CNA reached over and placed the nasal cannula in the resident's nose. After providing pericare and dressing the resident, the CNA assisted the resident to come to a sitting position, transfer to a wheel chair, and then moved the resident to the sink to wash her face and hands. During the move to the sink, the CNA removed the oxygen cannula from the resident's nose because the oxygen tubing was too short to stretch from the Oxygen concentrator to the sink. The resident was observed to become slightly short of breath, and have occasional deep, short coughs with the increased activity. When the resident was sitting in front of the sink, a LN entered the room and checked Resident #7's blood sugar. After checking the resident's blood sugar the LN placed a nasal cannula on the resident. The nasal cannula was attached to a portable oxygen tank on the back of the resident's wheel chair. The LN then filled a hand held nebulizer with a liquid solution and handed it to

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F 328	Continued From page 38 the resident. The resident was short of breath and her hands were shaking. The CNA commented to the LN that the resident was found with her oxygen off when the CNA entered the room that morning. The CNA said the resident was, "Dusky." The LN left the room, after the breathing treatment, without assessing the resident (e.g. lung sounds) or requesting the residents oxygen level or vital signs be checked. The resident's shortness of breath did improve after the breathing treatment. On 11/19/08 at 9:45 a.m., Resident #7 was observed sitting in her wheel chair in the activity room. She did not have oxygen on. Two CNAs approached the resident and quietly asked her if she needed to go to the bathroom. The resident acknowledged that she did, the CNAs wheeled her to the bathroom and transferred her to the toilet. After the resident used the toilet the CNAs assisted her to stand, provided peri-care, and then transferred her back to the wheelchair. After the transfer back to her wheel chair, the resident's hands were shaky, her fingers and lips had become slightly dusky, and she had an occasional deep, short cough. The CNAs placed a nasal cannula, which was attached to the portable oxygen tank on the back of the resident's wheel chair, in the resident's nose and turned the oxygen on. The CNAs moved the resident's wheel chair to the door to take her back to the activity room. The surveyor stopped the CNAs and asked them to check the resident's oxygen level. One CNA left the room and returned with a pulse oximeter and the day shift LN charge nurse (CN). The CNA checked the resident's SpO2 which read 84%. The CN did not assess the resident (e.g. lung sounds) or request that a set of vital signs be taken. The charge	F 328		

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F 328	Continued From page 39 nurse did ask the CNAs to recheck the resident's SpO2 in, "5 minutes." The resident was then taken back to the activity room. The resident was again observed at 10:15 on 11/19/08. The resident was no longer shaky or dusky. The CN reported the resident's SpO2 was 95% when the CNAs rechecked it. The resident continued to receive oxygen at 2 liters. On 11/19/08 at 10:35 a.m., the day shift CN was interviewed regarding Resident #7's SpO2 monitoring and breathing treatments. When asked how often the resident's SpO2 was checked, the charge nurse stated they were to be checked, "PRN", but the nurses generally checked the SpO2 at least once per shift. When asked when the resident received her breathing treatments the charge nurse stated routinely, "4 times per day" and then, PRN (as needed). When asked when staff administered oxygen to Resident #7, the CN stated the night shift placed the resident on oxygen every night and they took it off in the morning before taking her to breakfast. It was not placed back on the resident unless she needed it, e.g. she became anxious, restless, of short of breath. When asked if the SpO2 was checked prior to the resident being taken off the oxygen in the a.m., the CN stated no, CNAs generally waited to check the SpO2 until after the resident had been up for a while and went to breakfast. The SpO2 was then checked and the resident placed on oxygen if the SpO2 was under 90%. When asked how they decided how much oxygen to place on the resident the CN stated, "It depends." She stated the lower the SpO2 was the higher the oxygen liter flow would be. She stated once the SpO2 level went above 90% the liters were either decreased or the oxygen was taken off.	F 328		

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F 328	Continued From page 40 11/20/08 at 8:00 a.m., Resident #7 was observed waiting for breakfast in the activity/dining room. The resident was sitting in her wheel chair and did not have oxygen on. The resident was not short of breath, shaky, or dusky. During an observation at 9:05 a.m. on 11/20/08, Resident # 7 was being assisted to eat breakfast by the CN who sat at the resident's left hand side. The resident did not have oxygen on. The resident held a coffee cup in her hand and the CN was giving her a bite of food. When the resident lifted the coffee cup to her mouth the resident's hands were shaky, pale, and dusky. The resident's lips were also dusky with a pale halo around their circumference. The CN cued the resident to take another bite of food and then turned to a second resident sitting at the same table to verbally cue that resident to eat. Because of the circumoral pallor and cyanosis, as well as the shaky/dusky hands, the surveyor asked the CN to check the resident's SpO2 level. The CN commented staff generally checked the SpO2 after breakfast because staff did not like to interrupt the resident's meal. The surveyor repeated the request and the CN pulled the oximeter machine to the resident to check the SpO2. The SpO2 read 74% and the CN placed the resident on 3 liters of oxygen by nasal cannula. It took approximately 15 minutes for the Resident #7's SpO2 to go above 90%. At 9:20 a.m., the resident's SpO2 was 97%. The resident's hands were a light pink and she was no longer shaky. The resident's lips were still slightly dusky put the circumoral pallor was gone. The CN turned the oxygen level down to 1.5 liters and took the resident to her room to assess her lung sounds and take vital signs.	F 328		

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F 328	Continued From page 41 On 11/20/08 at 11:30 a.m., the DON and facility consultant were informed of the concerns regarding Resident #7's observed SpO2 levels, the absence of specific guidelines and parameters for monitoring SpO2 levels and administering prn oxygen on the physician orders and care plan, and the routine administration of the Duoneb versus PRN as ordered by the physician. On 11/21/08 at 11:00 a.m., the DON stated Resident #7's orders for the Duoneb had not been updated to reflect the resident was to receive the medication on a routine basis. The DON indicated the physician had previously given an order to change the DUO neb from PRN to routine, but the order was not written. The DON stated she had talked to the physician's office about this and about the need to clarify the SpO2 and PRN O2 orders. The DON also provided a copy of the facility's Oxygen Administration Documentation Guidelines. The guidelines instructed staff to evaluate and document, "[The] Resident's response, as related to the initiation of oxygen therapy and as needed [including]: Effectiveness of oxygen therapy, vital signs before and after therapy... Signs and Symptoms of hypoxia [including] increased rate of respirations or irregular respiratory patterns... Decreased lung sounds, adventitious sounds...Dyspnea... and Pallor, cyanosis. The DON acknowledge the nurses documentation did not consistently address the required areas. 2. Resident #6 was admitted to the facility on 3/20/08, with dementia, residual weakness from an old cerebral vascular accident, and swallowing difficulties with peg tube placement.	F 328		

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F 328	Continued From page 42 The resident's current Physician Recapitulation Orders (Recaps), dated 11/1/08 - 11/30/08, listed two respiratory care orders with a start date of 9/18/08: *"Duoneb nebulizer 2X/day [Duoneb... twice per day]." *"Pulmonary Toilet 3X [three times] daily - Respiratory Therapy..." Resident #6's MARs, Treatment Records, and Nurse Progress notes for 10/08 and 11/08, documented the resident received Duoneb treatments two times per day during the past two months. The records did not document that the resident received the Pulmonary Toileting. On 11/20/08 at 10:40 a.m., the LN Charge Nurse (CN) was asked if Respiratory Therapists provided Pulmonary Toileting for Resident #6. The CN stated no, the LNs provided the Pulmonary Toileting. The CN stated they did chest percussions on the resident when provided his Duoneb therapy. When asked if the resident received any other Pulmonary Therapy on a daily basis the CN stated no. The CN acknowledge the Pulmonary Toileting was not documented. During an interview on 11/21/08 at 11:30 a.m., the DON confirmed the resident was only receiving the Pulmonary Toileting two times per day, with the Duoneb treatment. The DON acknowledged that the LNs had not documented the performance of Resident #6's Pulmonary Toileting. Resident #6 was observed throughout the day on 11/18/08 and 11/19/08. The resident did not experience shortness of breath or respiratory	F 328		

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F 328	Continued From page 43 distress during the observations. The surveyor was not able to observe Resident #6 receive Pulmonary Toileting. The resident experienced a change in medical condition, related to other health issues, was transported to the Emergency Room twice during the survey, and hospitalized for a peg tube replacement on 11/21/08. 3. Resident #12 was admitted to the facility on 11/11/05 and was readmitted on 4/18/07 with the diagnoses of pneumonia, Parkinson's disease, arthritis, and atrial fibrillation. Resident #12's most recent annual MDS assessment, dated 9/19/08, documented the following: * Both short-term and long-term memory problems * Moderately impaired cognitives skills for daily decision making * Oxygen therapy a. Resident #12's physician order, dated 6/15/07, documented, "O2 @2-4/L PRN to keep SPO2 >90% via N/C [Oxygen at 2 to 4 liters per minute as needed to keep oxygen saturation greater than 90 percent by nasal cannula]." A 5/5/08 physician order for the resident documented, "O2 2L Nasal Cannula." Resident #12's care plan contained the problem, dated 9/23/08, "Breathing patterns, impaired R/T A-Fib [related to atrial fibrillation] R/T decreased SPO2." One of the approaches documented, "Oxygen at 1-4 L/min via PRN as ordered."	F 328		

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F 328	Continued From page 44 The facility completed a Condition Change Form on 9/25/08, which documented, "O2 Sat[uration] 95%, O2 on 1L, O2 via N/C." Resident #12's November 2008 CNA Flow Sheet Record documented, "Oxygen at 1-4 L/min via PRN as ordered." On 11/21/08 at 7:15 am, Resident #12 was observed in her room asleep in her wheelchair. The resident did not have oxygen on, although an oxygen concentrator was observed in the room. She displayed no shortness of breath or skin color symptomatic of hypoxia. On 11/21/08 at 8:30 am, the DON was interviewed concerning Resident #12's conflicting oxygen orders. Later, the surveyor was provided with a copy of a physician telephone order, dated 11/21/08 at 10:45 am, which documented, "D/C [discontinue] O2 @ 2L continuous flow by NC [nasal cannula]," and "O2 1-4 L/min NC while in bed et [and] PRN when up in chair." b. Resident #12's care plan contained the problem, dated 9/23/08, "Breathing patterns, impaired R/T A-Fib [related to atrial fibrillation] R/T decreased SPO2." One of the approaches documented, "Measure oxygen saturation as ordered." Review of Resident #12's record showed no physician order concerning measuring oxygen saturation. Resident #12's Vital Sign Flow Sheet revealed oxygen saturations had been measured 35 times from 7/24/08 to 11/20/08. The frequency varied	F 328		

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F 328	Continued From page 45 from daily for some periods of time to weekly. On 11/21/08 at 8:30 am, the DON was interviewed concerning Resident #12's oxygen saturation measurement lacking a physician order. Later, the surveyor was provided with a copy of a physician telephone order, dated 11/21/08 at 10:45 am, which documented, "O2 Sats daily et with VS [oxygen saturations daily and with vital signs."	F 328		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329	F329 **Resident Specific** **Resident # 5 physician was notified regarding lack of thyroid function laboratory monitoring. The plan of care and orders were updated as indicated.** **Other Residents** **The LN management team reviewed resident orders for validation that appropriate laboratory monitoring was in place. Physicians were notified, orders received, and plans of care updated as indicated.** **Facility Systems** **Laboratory monitoring needs are reviewed with the physician upon admission and with medication changes. Pharmacy consultant validates, recommending additional items for review as needed. Laboratory monitoring needs are placed upon Physician Recapitulations Orders for timely implementation. LN staff re-education is provided regarding laboratory requirements in relation to medication use.**	

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F 329	Continued From page 46 by: Based on observation, interview, and record review it was determined the facility did not ensure that residents' medications were monitored for ongoing need and effectiveness. This was true for 1 of 9 (#5) sampled residents reviewed. The findings include: Resident # 5 was admitted to the facility on 1/29/04. The resident's current diagnoses included Alzheimer, depression, and hypothyroidism. The resident's current Physician Recapitulation Orders (Recap Orders), dated 11/1/08 thru 11/30/08, included an order for, "Synthroid (Levothyroxine Sodium) 75 mcg tablet po daily (Synthroid 75 microgram tablet by mouth)." The Recap Order documented the originating date for the Synthroid 75 mcg was 4/11/2006. Resident #5's medical record, for 11/2007 through 11/2008, did not contain laboratory reports or other records monitoring the resident's thyroid functioning levels or the ongoing need for, or effectiveness of, the resident's current thyroid medication regime. On 11/20/08 at 11:10 a.m., the DON was interviewed regarding the absence of thyroid function levels and monitoring in Resident #5's record. After reviewing the resident's record and checking for monitoring results, the DON reported that thyroid function levels had not been conducted or reported since July 2006. She also acknowledged that no other monitoring information was available. Table I, F329 (Unnecessary Drugs) advises that,	F 329	**Monitor** **The DNS and/or designee will perform periodic review of Physician Recapitulation Orders and laboratory draws for appropriate medication monitoring through laboratory testing. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust frequency of the monitoring, as it deems appropriate.** **Date of Compliance** **December 26, 2008**	

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F 329	Continued From page 47 "Assessment of thyroid function (e.g.TSH, serum T4 or T3) [Serum Thyroid Stimulating Hormone, Thyroxine, or Triiodothyronine] should occur prior to initiation and periodically thereafter..." for all thyroid medications.	F 329		
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to: 1) Maintain the chemical sanitizing solution at the appropriate concentration, 2) Ensure the service area wiping cloths were placed in a chemical sanitizing solution of appropriate concentration, and 2) Ensure cleaned and sanitized serving plates were maintained under sanitary conditions. This affected 1 of 9 (#s 1 - 9) sampled residents and had the potential to affect all residents who dined in the facility. Findings include: 1. During a tour of the kitchen on 11/19/08 at 9:40 a.m., a red bucket was observed sitting inside the food preparation sink. The bucket was filled with a liquid solution. The Registered Dietitian (RD), who accompanied the surveyor, stated the liquid solution was quaternary sanitizing solution. The	F 371	F371 **Resident Specific** No specific resident numbers were indicated. However, there have been no symptoms of food borne illness. The plates in the warmer are now covered and cleaning cloths used with sanitizing solution concentration of 150 to 200 ppm. **Facility Systems** Food service staff are educated during orientation, annually, and as needed thereafter related to sanitation. Food service staff is re-educated to covering the plate warmer and cleaning cloths used with sanitizing solution concentration of 150 - 200 ppm. The Dietary Manager and/or Registered Dietician observe for proper dishware storage, required sanitizing solution concentration, and cloth use. **Monitor** The ED and/or designee will perform periodic review for dishware storage, required sanitizing solution concentration, and cloth use. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust frequency of the monitoring, as it deems appropriate. **Date of Compliance** December 26, 2008	

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F 371	Continued From page 48 surveyor requested and the staff measured the solution concentration. The concentration measured less than 100 parts per million (ppm). The Dietitian stated that no one individual was assigned to check or change the solution on a regular basis. The surveyor and RD reviewed the manufacturer's recommendations that indicated the sanitizing solution should be maintained at a concentration of 150 to 200 ppm. The State Operations Manual (SOM) Appendix PP, dated 8/1/08, indicates, "... cloths used for wiping surfaces during the kitchen's daily operation, be stored in containers filled with sanitizing solution at the appropriate concentration per manufacturer's specifications (see Manual Washing and Sanitizing section). Periodically testing the sanitizing solution helps assure that it maintains the correct concentration." 2. On 11/19/08 from 11:40 a.m. to 12:15 p.m., the tray line service was observed. A wiping cloth was observed laying on a food preparation surface. The cook was observed to pick up the cloth and wipe down the surfaces of the food preparation counters, the top of the steam table, and the serving bar above the steam table. The cook was not observed to place the wiping cloth in sanitizing solution prior to using it to wipe down the surfaces. The cook then returned the wiping cloth to the original location on the food preparation surface. The wiping cloth remained on the food preparation surface throughout the entire observation period. 3. Throughout the survey process from 11/17/08 through 11/19/08, serving plates were observed stacked and stored serving side up in a warming	F 371		

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F 371	Continued From page 49 unit. During the observations the plates were open to the air and not covered to protect the serving surfaces from possible contamination. During the tray line observation on 11/19/08 at 11:40 a.m., the stack of plates continued to be stored serving side up and uncovered in the warming unit. At 11:50 a.m., the surveyor observed the cook remove the first plate from the uncovered stack of plates in the warming unit. The cook used the first plate to dish up a serving of pork loin and potatoes. The plate was then covered and transferred to a cart to be transported to the Tuscany dining room. The State Operations Manual (SOM) Appendix PP, dated 8/1/08, indicates, "...stored dishes..should be stored in a clean dry location and not exposed to splash, dust or other contamination..." During an interview on 11/21/08 at 2:30 p.m., the FSM was informed of the deficient practice of placing the wipe cloth on the food preparation counter, between use, and not placing the wipe cloth in a sanitizing solution. The FSM stated that was not their usual practice and kitchen staff would be re-educated to either dispose of wipe cloths after use or place them in sanitizing solution. The FSM also indicated that in the future plates would either be stored serving side down or the warming cart would be covered. This is a repeat deficiency from the recertification survey conducted on 8/24/07.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed	F 428	**F428** **Resident Specific** **Resident #'s 5 & 16 were reviewed by the pharmacist with recommendations sent to**	

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F 428	Continued From page 50 pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility's pharmacist did not identify and report the following irregularities during Monthly Medication Regimen Reviews (MMRs) for two residents: 1. The lack of monitoring lab work for Resident #5 who received thyroid medication. 2. A medication dose discrepancy that occurred on three consecutive months of Resident #16's Physician's Recapitulation (Recap) Orders. This was true for 1 of 9 sampled residents (#5) reviewed for Monthly Drug Regimen Reviews, and 1 random resident (#16) observed during a medication pass. The findings include: 1. Resident #5 was admitted to the facility on 1/29/04. The resident's current diagnoses included Alzheimer's, depression, and hypothyroidism. The resident's current Recap Orders, dated 11/1/08 thru 11/30/08, included an order for, "Synthroid (Levothyroxine Sodium) 75 mcg tablet po daily (Synthroid 75 microgram tablet by mouth)." The Recap Order documented the originating date for the Synthroid 75 mcg was 4/11/2006.	F 428	the physician and implemented as ordered. The Physician's Recapitulation Orders have been updated. **Other Residents** The LN management team and pharmacist completed a thorough review for laboratory needs and medication dose discrepancies. Physicians were notified, orders received, and plans of care updated as indicated. **Facility Systems** MR completes data entry of all physician directed care and prints a monthly Physician's Recapitulation Order form. LN staff review for accuracy. The pharmacist reviews the Physician's Recapitulation and current care needs making recommendations for needed laboratory monitoring. Physicians are notified, orders received, and plans of care updated as indicated. LN staff, pharmacist, and MR are re-educated to the drug regime review process. **Monitor** The DNS and/or designee will perform monthly review of Physician Recapitulation Orders and pharmacy recommendations for accuracy. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust frequency of the monitoring, as it deems appropriate. **Date of Compliance** December 26, 2008	

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F 428	Continued From page 51 Resident #5's medical record, for 11/2007 through 11/2008, did not contain laboratory reports or other records assessing the resident's thyroid function. The residents MMRs for 11/2007 through 11/2008, did not identify or report the absence of thyroid function levels and other monitoring information. On 11/20/08 at 11:10 a.m., the DON was interviewed regarding the absence of thyroid function levels/monitoring in Resident #5's record. After reviewing the resident's record and checking for monitoring results, the DON reported that thyroid function levels had not been conducted or reported since July 2006. Table I, F329 (Unnecessary Drugs) advises that, "Assessment of thyroid function (e.g. TSH, serum T4 or T3) [e.g. serum Thyroid Stimulating Hormone, Thyroxine, or Triiodothyronine] should occur prior to initiation and periodically thereafter..." for all thyroid medications. 2. During a medication pass on 11/18/08 at 9:10 a.m., a LN was observed to administer two capsules of Depakote (Valproic Acid) 125 mg [milligrams] to Random Resident #16. The blister pack the LN took the medications from was labeled, "Depakote 125 mg 2 every a.m." The current Physician's Recapitulated Orders (Recap), dated 11/1/08 - 11/30/2008, documented the Resident #16 was to receive "Depakene sprinkles 125 mg q [every] a.m. [morning]." Further review of the resident's medical record revealed a Physician's Telephone Order, dated 8/21/08, which changed the a.m. dose of	F 428		

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F 428	Continued From page 52	F 428		

Depakene 125 mg to Depakote 250 mg. However, the Recap Orders for September, October, or November 2008 had not been updated to reflect the 8/21/08 change in the Depakote (Valproic Acid) order. All three Recap Orders continued to list, "Depakene sprinkles 125 mg q [every] a.m. [morning]." The Medication Administration Records (MARs) for September 2008 thru November 2008, contained hand written edits for the Depakene sprinkles which crossed out 125 mg, and changed it to 250 mg.

Resident #16's MMRs for September, October, and November 2008, did not identify or report the discrepancy between the most current Depakote order, the blister packs sent to the facility to administer the medication, and the resident's Recap Orders and the printed MARs.

On 11/20/08 at 8:10 a.m., the facility's pharmacy was contacted to verify the dosage they were sending for Resident #16's a.m. Depakote (Valproic Acid). The pharmacist confirmed they were sending 250 mg to be administered every a.m. The pharmacist stated the most current order they had for the Valproic Acid, dated 8/21/08, changed the dosage from 125 mg every a.m. to 250 mg. When asked if their pharmacy conducted the MMRs for the facility, the pharmacist stated their office was located out of state but they contracted with a local pharmacist to conduct the reviews. Two attempts were made to contact the local pharmacist responsible for the MMRs. The local pharmacist was on vacation and not available to answer the surveyor's questions.

On 11/20/08 at 8:45 a.m., the administrator was interviewed regarding the MMRs conducted at the facility. The administrator stated the pharmacist

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F 428	Continued From page 53 was expected to review all new physician's orders, the Recap Orders, and the MARs as part of the MMR.	F 428		
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to ensure all staff performed proper hand hygiene as indicated by accepted professional practice. This was true for 2 of 13 (#3 and #4) sampled residents. Findings include: According to October 25, 2002, Center for Disease Control guidelines, "The use of gloves does not eliminate the need for hand hygiene. Likewise, the use of hand hygiene does not eliminate the need for gloves. Gloves reduce hand contamination by 70 percent to 80 percent, prevent cross-contamination and protect patients and health care personnel from infection." 1. Resident #3 was admitted to the facility on 10/29/08 with the diagnoses of spinal cord injury, constipation, neuropathy, and muscle spasms. Resident #3's admission MDS assessment, dated 10/22/08, documented the following: * Short-term memory loss * Modified independence for cognitive skills for daily decision making	F 444	F444 **Resident Specific** The SDC, DNS, and/or designee reviewed resident #'s 3 & 4 related to infection control techniques with handwashing. Direct care staff was coached on infection control techniques with appropriate handwashing and glove use. **Other Residents** The LN management team reviewed other residents requiring foley and incontinent care by direct care staff. Re-education and skills checks for competency is initiated for direct care staff related to handwashing and glove use. **Facility Systems** Direct care staff receive education upon hire and at least annually regarding infection control with individual skill checks demonstration for competency in handwashing. SDC, DNS, LN management team, and/or designee will observe for compliance with infection control practices during daily routine rounds. **Monitor** The DNS and/or designee will round and observe handwashing practices and glove use. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust frequency of the monitoring, as it deems appropriate.	

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F 444	Continued From page 54 * Indwelling catheter * Urinary tract infection in the past 30 days Resident #3's November 2008 Flow Sheet Record documented, "Daily F/C Care Q shift [Daily Foley catheter care every shift]." On 11/18/08 at 1:55 pm, a CNA performed peri care on Resident #3 while the resident was in bed. She removed her gloves afterwards, but did not wash her hands or use hand sanitizer, and donned a new pair of gloves. She then performed catheter care for Resident #3. 2. Resident #4 was admitted to the facility with diagnoses of diabetes mellitus type two, amputation legs bilateral, hypertension, and peripheral vascular disorder. The most recent significant change MDS, dated 8/22/08, documented the resident; * had intact short and long term memory, * had modified independence for cognition, * required assistance of one for personal hygiene and dressing, * was incontinent of bowel and bladder. On 11/18/08 at 7:38 a.m., morning care was observed being completed on Resident #4 by two CNA staff. The resident was incontinent of urine, the CNAs applied gloves and performed peri care. After they finished with the peri care they applied incontinent briefs, shorts and a shirt. The CNAs then rolled the resident from side to side putting the sling for the mechanical lift beneath him. At 7:43 a.m., after the sling was in position, the CNA staff then removed their gloves but did not sanitize their hands. The mechanical lift was	F 444	**Date of Compliance** **December 26, 2008**	

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	135093	A. BUILDING _____ B. WING _____	11/21/2008

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F 444	Continued From page 55 brought in the room and the resident was transferred to the wheelchair. CNA#1 proceeded to tie up the garbage, wash hands and then left the room with the garbage. CNA#2 pushed the resident up to the sink and assisted the resident with combing his hair. At 7:51 a.m. CNA#2 pushed the resident to breakfast, on the way stopped and used hand sanitizer in the hallway. On 11/21 at 11:30 a.m. the administrator and DON were informed of the observations of improper hand hygiene by staff. No further information was provided by the facility.	F 444		
F 445 SS=F	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure resident laundry was processed according to accepted infection control practices. This had the potential to affect 13 of 13 sampled residents (#s 1-13) and all other residents of the facility. The findings include: On 11/20/08 at 8:40 am, during the environmental tour, a laundry staff member was asked to explain the laundry process. As she explained how the dirty linens were processed, she donned protective equipment which had been stored on the top of the closest commercial washing machine . The protective equipment included an	F 445	F445 **Resident Specific** **No specific residents were identified. Hooks were installed on the clean and dirty sides of the laundry to provide clear separation for laundry staff protective equipment.** **Facility Systems** **Laundry staff is educated during orientation, annually, and as needed thereafter related to infection control. Re-location of the protective equipment was completed with education for technique and protective equipment storage. The laundry supervisor and/or designee observe for proper infection control practices and protective equipment storage.** **Monitor** **The ED and/or designee will perform periodic review for protective equipment storage and other potential infection control concerns in the laundry. Any concerns will**	

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F 445	Continued From page 56 apron labelled, "dirty linens," gloves, and forearm protectors. After showing how the dirty linens were processed, she removed the protective equipment and returned it to the top of the nearest commercial washing machine. On 11/20/08 at 5:00 pm, the Administrator was made aware of the dirty linen protective equipment stored on top of the commercial washing machine instead of the dirty linen area. He indicated that it would be taken care of.	F 445	be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust frequency of the monitoring, as it deems appropriate. **Date of Compliance** December 26, 2008	
F 465 SS=F	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to provide proper protection against cross-contamination of the potable water supply by allowing a sprayer hose to rest in the bottom of the beauty shop sink. The facility also failed to provide proper backflow prevention for washing machine and kitchen sink drains. This had the potential to affect all residents in the facility. The findings include: 1. On 11/18/08 at 10:50 am, the sprayer hose in the beauty shop sink extended approximately 12-14 inches down into the sink and came to rest near the drain. No retraction mechanism was installed on the sprayer hose and the hose was plumbed directly into the water supply without an atmospheric vacuum breaker to prevent cross-contamination of the potable water supply.	F 465	F465 **Resident Specific** No specific residents were identified. The beauty parlor sink sprayer was replaced with a retractable mechanism to prevent resting in the sink bottom. Back flow devices are installed on the washing machine drains and the kitchen skin drain space adjusted. **Other Residents** The IDT made rounds to identify other potential potable water supply concerns. No additional concerns were identified. **Facility Systems** The potable water supply issues will be monitored with monthly routine preventative maintenance rounds. The maintenance staff is educated on required drain spacing and back flow issues. **Monitor** The ED and/or designee will perform periodic review for safety of potable water system. Any concerns will be addressed immediately and discussed with the PI	

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F 465	Continued From page 57 On 11/19/08 at 2:00 pm, the sprayer hose was again observed to be resting in the sink near the drain. On 11/19/08 at 4:10 pm, the administrator was made aware of the lack of prevention for cross-contamination with the beauty shop sink and sprayer hose. He indicated that it would be taken care of. 2. On 11/20/08 at 8:45 pm, the two commercial washing machines were observed. The washing machines drains were plumbed directly into the main drain without any air gaps to prevent backflow into the washing machines. Backflow into the washing machines could potentially contaminate resident linens and pose a health risk to laundry staff. The administrator and maintenance director, who were both present, stated they would find out if there were either internal check valves in the machines or a check valve on the main drain. On 11/21/08 at 3:30 pm, the facility's contracted plumber stated that he would install a check valve on the main drain to prevent backflow. 3. During a tour of the kitchen on 11/19/08 at 1:30 a.m., the food preparation sink, steam cooker, and dishwasher were observed. Two open drainage pipes were observed under the food preparation sink. One of the pipes ran from the food preparation sink to the drain basin under the sink. The other pipe ran from the steam cooker into the same drain basin. Both pipes were approximately 2 inches in diameter and sat at or below the water line of the basin. In addition, another 2 inch drain pipe was observed running from the dishwasher to a drain basin under the dishwasher. The opening of this pipe was also	F 465	committee as indicated. The PI committee may adjust frequency of the monitoring, as it deems appropriate. **Date of Compliance** December 26, 2008

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F 465	Continued From page 58 level with the water line of the basin. The lack of air gap between the drain pipes and water line on the drain basins created the potential for a negative back flow of fluid from the drain into the food preparation sink, the food steamer, and the dishwasher. No adjacent back flow prevention valves were observed. On 11/19/08 at 2:00 p.m., the maintenance director was notified of the lack of backflow prevention in the kitchen. At 2:10 p.m., the maintenance director and the facility's contracted plumber confirmed the lack of airgap under the food preparation sink and the dishwasher. The plumber also confirmed there were no adjacent back flow prevention devices. On 11/19/08 at 2:30 p.m., the maintenance director reported the pipes had been trimmed to provide an airgap between the pipes and the drain basin. At 2:35 p.m., the surveyor observed that the opening to each of the pipes rested at least 4 inches above the water line of each basin.	F 465	

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual State relicensure survey of your facility. The surveyors conducting the survey were: Mark Sawmiller, RN, Team Coordinator Arnold Rosling, RN, QMRP Lorraine Hutton, RN Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record FSM = Food Service Manager	C 000	**This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Aspen Healthcare Center does not admit that the deficiencies listed on the State Form exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.** RECEIVED DEC 22 2008 FACILITY STANDARDS	
C 125	02.100,03,c,ix ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F164 as it relates to the privacy of residents.	C 125	**Refer to the Plan of Correction at F164.**	

Bureau of Facility Standards

Brian V. Sawyer — Executive Director — 12/18/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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C 175	Continued From page 1	C 175		
C 175	02.100,12,f f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Refer to F225 as it relates to the investigation of injuries.	C 175	**Refer to the Plan of Correction at F225.**	
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Refer to F371 as it relates to food prepared and stored in a sanitary manner.	C 325	**Refer to the Plan of Correction at F371.**	
C 342	02.108,04,b,ii ii. All toxic chemicals shall be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Refer to F323 as it relates to the storage of chemical hazards.	C 342	**Refer to the Plan of Correction at F323.**	
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT 07. Housekeeping Services and Equipment. Sufficient housekeeping and	C 361	**Refer to Plan of Correction at F252.**	

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C 361	Continued From page 2 maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Refer to F252 as it relates to a home-like environment.	C 361		
C 671	02.150,03,b b. Proper handling of dressings, linens and food, etc., by staff. This Rule is not met as evidenced by: Refer to F445 as it relates to laundering of linens in a sanitary manner.	C 671	**Refer to Plan of Correction at F445.**	
C 745	02.200,01,c c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Refer to F281 as it relates to care given according to accepted professional standards.	C 745	**Refer to Plan of Correction at F281.**	
C 782	02.200,03,a,iv iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 as it relates to revision of care plans.	C 782	**Refer to Plan of Correction at F280.**	

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C 784	Continued From page 3	C 784		
C 784	02.200,03,b b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Refer to F309 as it relates to care of hypoglycemia.	C 784	**Refer to Plan of Correction at F309.**	
C 790	02.200,03,b,vi vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 as it relates to the prevention of accidents.	C 790	**Refer to Plan of Correction at F323.**	
C 820	02.201,01,a a. Reviewing the medication profile for each individual patient at least every thirty (30) days. The attending physician shall be advised of drug therapy duplication, incompatibilities or contraindications. This Rule is not met as evidenced by: Refer to F428 as it relates to monthly review of residents' drug regimen.	C 820	**Refer to Plan of Correction at F428.**	